

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1958 CERTIFICATE OF DEATH

Reg. Dist. No.

01948

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick				o. STATE Md b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Frederick		c. LENGTH OF STAY IN 1b 2 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hosp.		d. STREET ADDRESS RURAL 06X-2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year
BABY GIRL				Albaugh	February 20 1958
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 20, 1958
9. AGE (In years lost birthday) yrs. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
10. BIRTHPLACE (State or foreign country) FREDERICK		11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY? MD	
13. FATHER'S NAME Fach R. Albaugh		14. MOTHER'S MAIDEN NAME Mary Burrier UNION BRIDGE		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT MARY B. ALBAUGH UNION BRIDGE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 2 hr.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X		Prenaturity			
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE A. M. Powell Jr. M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) A. M. Powell Jr. M.D. ADDRESS (Street, city or town, state) FREDERICK, Maryland 2/29/58 DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/58		22c. NAME OF CEMETERY OR CREMATORIUM PIPE CREEK GEM. CARROLL COUNTY MD	
22d. LOCATION (City, town, or county) (State)		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE D. D. Hartshorn, Union Bridg. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE D. D. Hartshorn, Union Bridg. Md.		ADDRESS 206923-3 X VI			
VS A15 (4) 15M 9/55					

## CERTIFICATE OF DEATH

1957

FEB 24 1958

RECEIVED

BUREAU V.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Item 9 File#226 3-3-58 et  
**1960 CERTIFICATE OF DEATH**

Reg. Dist. No.

01949

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1112 Motter Ave.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>1112 Motter Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Daisy</b>		First <b>Carrie</b>	Middle <b>fornia</b>
		Last <b>Nicholas</b>	4. DATE OF DEATH <b>Feb.</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <b>Mar. 7-1878</b>		9. AGE (In years last birthday) <b>79 80</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
10c. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Nichlas</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Chase</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>James E. Ambush Jr. 320 N. Bentz St.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b>		<b>Cerebral Vascular Accident</b> <b>2 yrs</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Sensitivity</b>			
(b) DUE TO <b>Senility</b>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-1</b> , 19 <b>58</b> , to <b>2-19</b> , 19 <b>58</b> that I last saw the deceased alive on <b>2-14</b> , 19 <b>58</b> , and that death occurred at <b>10 30</b> P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>Rex R Martin</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Rex R Martin</b>		35E. Church Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-22-58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Fairview</b>
22d. LOCATION (City, town, or county) <b>Frederick, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks</b>		23. ADDRESS <b>111 Frederick, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>FEB 25 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>Albert J. Smith</b>	

TO HOSPITAL  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU Y.

FEB 25 1953

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 F11mg226 3-6-58 et  
1961 CERTIFICATE OF DEATH

Reg. Dist. No.

01950

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Hagerstown</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>6 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>2212 Virginia Ave.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>I. O. O. F. Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Nellie</b>	Middle <b>Grace</b>	Last <b>Beesecker</b>	4. DATE OF DEATH	Month <b>Feb.</b>	Day <b>25</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 12 1887</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months <b>1</b>	IF UNDER 24 HRS. Days <b>12</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Resident</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William H. Beesecker</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Virginia Snyder</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Elsie Kline</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>To carcinoma Stomach</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio sclerosis</b> DUE TO (c) <b>6 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Redwood Rd.</b>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Oct. 1, 1957</b> to <b>Feb. 26, 1958</b> , that I last saw the deceased alive on <b>Feb. 24, 1958</b> , and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Wm. M. Smith M.D.</b>		ADDRESS (Street, city or town, state) <b>Hagerstown, Maryland</b>					DATE SIGNED <b>2-25-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 27-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>ROSE HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leaf Williamsport, Md</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>FEB 28 1958</b>		24b. REGISTRAR'S SIGNATURE <b>John Smith</b>		

TO HOSPITAL  
may be referred to the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87, ROMITA'S HEAD TO THE MEXICAN STATE OF GUADALAJARA

BUREAU V. S.  
FEB 28 1958  
REGISTRY ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01951

## 1999 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#5	c. LENGTH OF STAY IN lb 219 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital		d. STREET ADDRESS 23 Hamilton Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First SARAH	Middle SUSAN	Last BISER		
4. DATE OF DEATH February 10, 1958	Month	Day	Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Feb 1868	9. AGE (In years last birthday) 89 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph D. Wiles		14. MOTHER'S MAIDEN NAME Mary Jane Staub		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Clara V. Harshman	(Same as item #2) Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteria Tubercolosis		Chronic myocarditis		INTERVAL BETWEEN ONSET AND DEATH 4 yr.	
(c)				4 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)
19			7 N. Market St., Frederick, Md.		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. F. Kline</i> ADDRESS (Street, city or town, state) H. F. Kline, M. D. M.D. 7 N. Market St., Frederick, Md. DATE SIGNED 2-12-58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-58	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			ADDRESS	24a. REC'D BY REGISTRAR FEB 13 '58	24b. REGISTRAR'S SIGNATURE <i>Webb couch</i>
VS A15 (4) 15M 9/55			DATE		

## 1000 CERTIFICATE OF DEATH

Date of Birth

Place of Birth

Name of Hospital

Name of Doctor

BUREAU V.

FEB 13 1958

RECEIVED

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01952

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the Health Director.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tranit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) // Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 325 East Church	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle H Last Bowens		4. DATE OF DEATH Month Feburary Day 10 Year 1958	
5. SEX Male COLOR OR RACE Colored		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 2, 1892	
9. AGE (In years <small>last birthday</small> ) 66 <small>60</small> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer -Contractors	
10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Bowens	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 217-01-5861		17. INFORMANT Hospital records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b)		INTERVAL BETWEEN ONSET AND DEATH 7 hours	
(a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cloths caught fire, was unable to get them off	
20c. TIME OF INJURY Month, Day, Year Hour 6-30 <small>AM</small> 2/10/58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Frederick, Frederick, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Feburary 10, 1958	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		22b. BURIAL, CREMATION OR REMOVAL (Specify) Burial 22c. DATE THEREOF 2-12-58 22d. NAME OF CEMETERY OR CREMATORIUM Fairyview 22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III		ADDRESS Frederick, Md. 24a. REC'D BY REGISTRAR DATE FEB 14 '58 24b. REGISTRAR'S SIGNATURE <i>Alfred J. Edwards</i>	

WISCONSIN STATE DEPARTMENT OF HEALTH - DIVISION OF  
MEDICAL EXAMINER'S CEMETERY

STATE OF  
WISCONSIN

BUREAU V. S.  
RECEIVED  
FEB 14 1968  
10

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2000

## CERTIFICATE OF DEATH

Reg. Dist. No.

01953

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown-Rural RD#1		c. LENGTH OF STAY IN lb 34 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Adamstown-Rural RD#1				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Adamstown		d. STREET ADDRESS Near Adamstown				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHARLES		First	Middle	Last	4. DATE OF DEATH February 12,	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 June 1894		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John H. K. Boyer		14. MOTHER'S MAIDEN NAME Ella V. Stockman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-36-4265		17. INFORMANT Mrs. Mary M. V. Boyer (Same as item #1)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>177x</i> DUE TO <i>Carcinoma of the prostate</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>177x</i> DUE TO <i>Months</i> (c) <i>177x</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Middletown	(County)	(State)
21. I certify that I attended the deceased from <i>10/5/57</i> to <i>2/12/58</i> , that I last saw the deceased alive on <i>1/30/58</i> , and that death occurred at <i>6:15 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>James B. Thomas</i> , 228 N. Market St., Frederick, Md. DATE SIGNED 2-13-58								
PHYSICIAN'S NAME (Type) James B. Thomas, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-15-58	22c. NAME OF CEMETERY OR CREMATORIUM Reformed Cemetery	22d. LOCATION (City, town, or county) Middletown		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR FEB 14 '58	24b. REGISTRAR'S SIGNATURE <i>Ch. Leach</i>			

## CERTIFICATE OF DEATH

BUREAU V. A.

FEB 14 1933

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1963

## CERTIFICATE OF DEATH

01954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>resident</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>35 Brunswick</i>		d. STREET ADDRESS <i>--</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Hildred</i>	Middle <i>Louise</i>	Last <i>Brady</i>	4. DATE OF DEATH <i>Feb. 8 1958</i>	Month <i>Feb.</i>	Day <i>8</i>	Year <i>1958</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 18, 1926</i>	9. AGE (In years last birthday) <i>32 yrs.</i>	10. IF UNDER 1 YEAR Months <i>32</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Henry Dakin</i>		14. MOTHER'S MAIDEN NAME <i>Emma Elizabeth Heffner</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Model McGana</i>		17. INFORMANT <i>Address: Lantz, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>201X</i>		Hodgkin's Disease, generalized		DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO		(b) (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb. 1, 1958</i> , to <i>Feb. 8, 1958</i> , that I last saw the deceased alive on <i>Feb. 8, 1958</i> , and that death occurred at <i>11:00 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Thomas R. Reid M.D.</i>		ADDRESS (Street, city or town, state) <i>Professional Bldg. Frederick, Md. 2/9/58</i>					
PHYSICIAN'S NAME (Type) <i>Thomas R. Reid</i>		DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-11-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Locust Valley</i>		22d. LOCATION (City, town, or county) <i>Locust Valley</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elois J. Teeter</i>		ADDRESS <i>Brunswick, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>2/13/58</i>		24b. REGISTRAR'S SIGNATURE <i>Releasch</i>	

## CERTIFICATE OF DEATH

BUREAU Y. S

FEB 13 1968

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PN3. Page 5 may be retained by the funeral director. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No 1955

1964

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		d. STREET ADDRESS <b>50II Orleans Court</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>George</b>		First <b>Gregory</b>	Middle <b>Brockmeyer</b>	Last	4. DATE OF DEATH <b>Feburary 27</b>	Month	Day	Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>II/2/1896</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George Brockmeyer</b>				14. MOTHER'S MAIDEN NAME ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Ye</b> <input checked="" type="checkbox"/> If yes, give war or dates of service <b>World War</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospt. Records.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Pelvis, Femur and Ribs</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>					
978X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acetylsalicylic acid intoxication; Lacerated wrist&amp;hemorrhage</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Jumped out of third story window</b>							
20c. TIME OF INJURY Hour <b>11</b>	Month, Day, Year <b>2/27/58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, shop, office bldg., etc.) <b>Hotel</b>	20f. (City or town) <b>Frederick</b>	(County) <b>Frederick, Md.</b>	(State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>B.O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>2/28/58</b>				
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <i>Adelbert Nat.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3-4-58</b>	22c. TIME OF BURIAL OR CREMATION <b>11:00 AM</b>	22d. LOCATION (Name of cemetery) <b>Frederick</b>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>Timothy Hanlon-3831-G-Aud-N.Y.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>MAR 6 '58</b>	24b. REGISTRAR'S SIGNATURE <i>John Hanlon</i>						

UNIVERSITY-SYRACUSE DEPARTMENT OF HEALTH-SCIENCE  
MEDICAL EXAMINERS CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

AGE

SEX

RACE

RELIGION

EDUCATION

EMPLOYMENT

HOBBIES

INTERESTS

EXTRA-CURRICULAR ACTIVITIES

MEMORIALS

OBITUARY

NOTES

REMARKS

TESTIMONY

WITNESSES

APPROVAL

SIGNATURE

DATE

TIME

YEAR

MONTH

DAY

YEAR

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 226 3-2-50 a.m.s MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01956

1. PLACE OF DEATH a. COUNTY Frederick		1965		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Middletown		d. STREET ADDRESS /	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clark		First	Middle	Last	4. DATE OF DEATH Month 2 Day 12 Year 1958		
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/17/1941	9. AGE (in years last birthday) 16 yrs.	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Clark V. Brown		14. MOTHER'S MAIDEN NAME Mary Floyd					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Reuben Baker, Middletown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 844 X DUE TO Clostridia Welchii INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (b) DUE TO Infection and intoxication (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Coasting Accident - sled runner penetrated thigh					
20c. TIME OF INJURY Month, Day, Year Hour p.m. 7 - 8, 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) Middletown (Rural) Frederick Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dr. B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 2/12/1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/15/1958		22c. NAME OF CEMETERY OR CREMATORIUM Harmony Cemetery		22d. LOCATION (City, town, or county) Frederick Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 14 '58		24b. REGISTRAR'S SIGNATURE A. L. Schubert	

RECEIVED

BUREAU U. S.

FEB 14 1958

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Items 8,9 Film G226 3-12-58 et

Reg. Dist. No. 1957

FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Five East of Libertytown On Buffalo Road</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Centerville</b>		d. STREET ADDRESS <b>Ijamsville P.O.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Norris</b>		First	Middle	Last	4. DATE OF DEATH Month	Month	Doy
				<b>Brown</b>	<b>February</b>	<b>26</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>1898</b>	9. AGE (in years from birthday) <b>58 59 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	<b>June-18-1900</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor tavern</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Luther Brown</b>		14. MOTHER'S MAIDEN NAME <b>Ollie Bowie</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
		<b>219-20-2701</b>		<b>Margaret Brown- Ijamsville P.O. Fred. Co. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive failure</b> <i>(Cardiac)</i> INTERVAL BETWEEN ONSET AND DEATH							
443X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sclerotic heart disease</b>							
DUE TO (c) <b>Hypertension</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
19							
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/26/58</b>	
EXAMINER'S NAME (Type) <b>B. O. Thomas</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 2-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Eberneez</b>		22d. LOCATION (City, town, or county) <b>Centerville-Fred. Co. Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III Frederick, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>DeL. Smith</i>	
						DATE <b>MAR 4 '58</b>	

DEPARTMENT OF JUSTICE - BUREAU OF INVESTIGATION  
FEDERAL BUREAU OF INVESTIGATION - CERTIFICATE OF DEATH

STATE OF CALIFORNIA  
SACRAMENTO

BUREAU U. S.  
RECEIVED  
MAR 4 1939

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2002 CERTIFICATE OF DEATH

Reg. Dist. No. 81958

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Frederick</i>				a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Rural-Broadneck Hotel</i>		<i>2 mo.</i>		<i>Rural - Lewistown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Hindabone Convalescent &amp; Rest Home</i>					
3. NAME OF DECEASED (Type or print)	First <i>JONAS</i>	Middle <i>LEYI</i>	Last <i>BURRIER</i>	4. DATE OF DEATH	Month <i>Feb.</i> Year <i>1958</i>
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Nov. 12, 1880</i>	9. AGE (In years lost birthday) <i>77</i> yrs.	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
<i>Farmers</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Josiah Burrier</i>		14. MOTHER'S MAIDEN NAME <i>Levenia Long</i>		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no. or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-18-8404</i>		17. INFORMANT <i>A. Mrs. J. Thomas Jr., Adamstown, Md</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		PULMONARY ELEPHIASIS		INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>	
204.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Lungema</i>		Lungema		4 mo	
DUE TO cause (b) <i>Pneumocystic Carbovitis &amp; Cerebral Sclerosis</i>		Pneumocystic Carbovitis & Cerebral Sclerosis		1958	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 2, 1957</i> to <i>Feb. 1958</i> , that I last saw the deceased alive on <i>Feb. 2, 1958</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Jefferson Md</i>					
ACTUAL SIGNATURE <i>A. T. Brice</i>		DATE SIGNED <i>Feb. 13, 1958</i>			
PHYSICIAN'S NAME (Type) <i>A. T. Brice</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-11-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Chapel Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Nr. Libertystown</i>		(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>G.C. Barton, Walkersville</i>		ADDRESS <i>Walkersville</i>		24a. REC'D BY REGISTRAR DATE <i>Feb. 13 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU X. S.

FEB 13 1953

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1966 CERTIFICATE OF DEATH

01959

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/55

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb 12 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>78 Lincoln Apartments</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>78 Lincoln Apartments</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>RUDOLPH</b>	Middle <b>JAMES</b>	Last <b>CARROLL</b>	4. DATE OF DEATH	Month <b>February</b>	Day <b>17</b>	Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>14 May 1945</b>	9. AGE (In years (last birthday) yrs.) <b>12</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Viola May Carroll</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Viola M. Carroll (Same as item #1)</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>292.6</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  DUE TO  (b) <b>Crises with Liver infarct</b>  DUE TO  (c) <b>sickle cell disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>March</b>	Doy <b>19</b>	Year <b>1952</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)  <b>2 P</b>	(County)	(State)	
21. I certify that I attended the deceased from <b>March 1952</b> , to <b>17 Feb 1958</b> , that I last saw the deceased alive on <b>15 Feb 1958</b> , and that death occurred at <b>2 P.M.</b> , from the causes and on the date stated above.  ACTUAL SIGNATURE <b>RL Guest</b>						ADDRESS (Street, city or town, state) <b>M.D. 7 E. Church St., Frederick, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Russell L. Guest, M. D.</b>						DATE SIGNED <b>2-19-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-21-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Fairview Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>	(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Feb 21 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Deb. Leach</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1967 CERTIFICATE OF DEATH

01960

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Md.</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>4 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick Rural</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fred. Co. Chronic Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Jennie M.</b>	Middle <b>Chrissinger</b>	Last <b>Chri</b>	4. DATE OF DEATH	Month <b>2</b>	Day <b>3</b>	Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>1/10/1870</b>	9. AGE (In years lost birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months <b>88</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>private home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Linton Chrissinger</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Blumenauer</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Charles Smith, Jefferson, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>Arterio</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 yrs</b>
{ (b) DUE TO cause (a), stating the under- lying cause lost. (c)								<b>4 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Mid thigh &amp; hipputation bfr bg because of gangrenous toes</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from alive on <b>Jan 26</b> , 19 <b>58</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>H. Kline</b>		ADDRESS (Street, city or town, state) <b>711 Main St Frederick MD</b>						DATE SIGNED <b>Feb 4/58</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>2/5/1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) <b>Middletown, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Co., Middletown, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>FEB 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Asst. Director</b>		

TO HOSPITAL or attending physician:  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU V. S.

FEB 11 1958

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
Item 18 Film 226 3-10-58 ams

**CERTIFICATE OF DEATH**

Reg. Dist. No. 01961

1968

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Carroll</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Airy</i>		d. STREET ADDRESS <i>R.F.D. # 2</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		06X-2		
3. NAME OF DECEASED (Type or print) <i>Harry</i>		First <i>S.</i>	Middle <i>Christiansen</i>	Last <i>Christiansen</i>	4. DATE OF DEATH <i>Feb 27 1958</i>	Month <i>Feb</i>	Day <i>27</i>	Year <i>1958</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>June 4, 1918</i>	9. AGE (In years last birthday) <i>39 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Milwaukee, Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Harry E. Christiansen</i>		14. MOTHER'S MAIDEN NAME <i>Florence S. Scholtka</i>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>Mrs Florence Christiansen, Milwaukee, Wis.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <i>Meningitis, acute</i> DUE TO (etiological agent not isolated) <i>340.3</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>Prinnee Georges Co.</i> (State) <i>Md.</i>		
21. I certify that I attended the deceased from <i>2/26 1958</i> to <i>2/27 1958</i> , that I last saw the deceased alive on <i>2/27 1958</i> , and that death occurred at <i>2:30 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Henry V Chase M.D.</i> ADDRESS (Street, city or town, state) <i>415 Church St</i> DATE SIGNED <i>2/27/58</i> PHYSICIAN'S NAME (Type) <i>Henry V. Chase Frederick Md</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>March 1, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln</i>		22d. LOCATION (City, town, or county) <i>Prinnee Georges Co., Md.</i> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Olin L. Molesworth</i>		ADDRESS <i>Damascus, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 3 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Abraham</i>		

## CERTIFICATE OF DEATH

BUREAU V. S.

MAR 3 1962

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2903

## CERTIFICATE OF DEATH

Reg. Dist. No. 011962

1. PLACE OF DEATH o. COUNTY <b>FREDERICK</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b>		b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>		d. STREET ADDRESS <b>1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Millard</b>	Middle <b>CALVIN</b>	Last <b>COBLENTZ</b>	4. DATE OF DEATH	Month <b>Feb.</b>	Day <b>26</b>	Year <b>1958</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 - 9 - 91</b>	9. AGE (In years less birthday) <b>67</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Bus Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>transportation</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Calvin R. Coblenz</b>		14. MOTHER'S MAIDEN NAME <b>Lizzie Brandenburg</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-07-3867</b>		17. INFORMANT <b>Mrs. Pauline Coblenz, Middletown, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BENIGN PROSTATIC HYPERPLASIA with ACUTE OBSTRUCTION</b> DUE TO <b>610 X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE TO</b>		(b) <b>Post - OPERATIVE — PARALYTIC ILEUS 24 HRS.</b>							
		(c) <b>+ GASTRO - INTESTINAL HEMORRHAGE</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>101 FREDERICK SHOPPING CENTER</b>		(County)	(State)
21. I certify that I attended the deceased from <b>Feb. 23, 1958</b> , to <b>Feb. 26, 1958</b> , that I last saw the deceased alive on <b>26 Feb., 1958</b> , and that death occurred at <b>3:20 A.M.</b> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>ROBERT D. CROUCH</b>	
ACTUAL SIGNATURE <b>Robert D. Crouch</b>		DATE SIGNED <b>2/26/58</b>							
PHYSICIAN'S NAME (Type) <b>ROBERT D. CROUCH</b>		FREDERICK, MARYLAND 2/26/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3/1/1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) <b>Middletown, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Co., Middletown, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Feb 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Webb</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WYOMING STATE DEPARTMENT OF HEALTH-BULLETIN 78

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 23 1958

REGELV E D

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2004 CERTIFICATE OF DEATH

Reg. Dist. No.

01963

## 1. PLACE OF DEATH

o. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Walkersville

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

—

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

o. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Walkersville

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

CORK DEVILBISS

CRAMER

February 10

1958

## 5. SEX

F

## 6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

Aug. 17 1872

9. AGE (In years  
last birthday)

85 yrs.

## 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY

own home

## 11. BIRTHPLACE (State or foreign country)

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

Solomon D. Devilbiss

## 14. MOTHER'S MARRIED NAME

Henrietta Cronise

Address

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

If yes, give war or dates of service)

M

## 16. SOCIAL SECURITY NO.

—

## 17. INFORMANT

Miss Henrietta Cronise, Walkersville, Md.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Pulmonary oedema

INTERVAL BETWEEN  
ONSET AND DEATH

10 minutes

422.1

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

DUE TO

(b)

DUE TO

(c)

Arteriosclerotic CVD

10 YEARS

## MEDICAL CERTIFICATION

## 19. WAS AUTOPSY PERFORMED?

YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. 19  
p. m.20d. INJURY OCCURRED  
White Not white  
of work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 1 April 1950, to 2/10/58, that I last saw the deceased alive on 10 February 1958, and that death occurred at 11 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

James E. Stoner Jr.

M.D.

WALKERSVILLE, MD. 2/1/58

PHYSICIAN'S  
NAME (Type)

JAMES E. STONER, Jr.

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

2/13/1958

## 22c. NAME OF CEMETERY OR CREMATORIUM

Glade cemetery

## 22d. LOCATION (City, town, or county)

Walkersville

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

G.C. Barton

## ADDRESS

Walkersville, Md.

## 24a. REC'D BY REGISTRAR

FEB 13 '58

## 24b. REGISTRAR'S SIGNATURE

A. L. Lewis

## CERTIFICATE OF DEATH

REGISTRATION NO.	100-0000000	NAME OF MOTHER	JOHNSTON, MARY
SEX	MALE	NAME OF FATHER	JOHNSTON, JOHN
AGE	35	ADDRESS	1234 FAIRFIELD DR., MILWAUKEE, WI 53215
DEATH DATE	10-10-1988	TIME	10:00 AM
PLACE OF DEATH	HOME	CAUSE OF DEATH	HEART DISEASE
DEATH CERTIFIED BY	DR. JAMES H. SMITH	DEATH CERTIFIED AT	MILWAUKEE, WI
DEATH CERTIFIED ON	10-10-1988	BY	DR. JAMES H. SMITH
RECEIVED BY			
BUREAU V.			
OCT 12 1988			
RECEIVED			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2905 CERTIFICATE OF DEATH

Reg. Dist. No. 1964

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland		b. COUNTY	Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Walkersville		14 yrs.		Walkersville						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION										
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
WILLIAM		WALTER	CULLER	Feb.	26	1958				
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	Months	Days	Hours	Min.
m	w	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 15, 1877	80 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Farmer		own farm		Maryland		U.S.A.				
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME								
William L. Culler		Sarah Krautz								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No		312-24-6320		Mr. W. Walter Culler, Jr., Walkersville, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial infarction				9 days				
420.1		DUE TO				9 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		Coronary thrombosis		10 years				
{		DUE TO		Arteriosclerotic cardiovascular disease						
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
19										
21. I certify that I attended the deceased from November 19, 1953, to 26 Feb., 1958, that I last saw the deceased alive on 25 February, 1958, and that death occurred at 5 A.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE		James E. Stoner, Jr.		M.D.						
PHYSICIAN'S NAME (Type)		JAMES E. STONER, Jr.		WALKERSVILLE, Md		2/26/58				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR Crematory		22d. LOCATION (City, town, or county)		(State)		
Burial		2/28/58		St. Luke's Lutheran		Feagansville		Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
G. C. Barton		Walkersville, Md.		FEB 28 1958		John Smith				

87. 2010MNRAS.401.2450 BOUDREAU-LEBLOND ET AL. 61

BUREAU V.

FEB 28 1959

PREGEIY ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2006

## CERTIFICATE OF DEATH

01965

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Foxville</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Foxville</b> (Smithsburg R.F.D.)	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>VIOLA</b>		4. DATE OF DEATH Month Day Year <b>Feb. 11. 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 6 1869</b>
9. AGE (In years last birthday) yrs. <b>88</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Foxville, Fredk. Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Allen E. Hayes</b>		14. MOTHER'S MAIDEN NAME <b>Martha Kesselring</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No. Mrs Fern Fox, Lantz, MD.</b>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>421.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 11</b> , 19 <b>58</b> , to <b>Feb. 11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb. 11</b> , 19 <b>58</b> , and that death occurred at <b>Thurmont, Md.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>James K. Gray</b>		ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b> DATE SIGNED <b>1958</b>	
PHYSICIAN'S NAME (Type) <b>James K. Gray</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>Feb. 15. 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Bethel M.E.Cem</b>	
22d. LOCATION (City, town, or county) <b>Nr. Garfield, Fredk. Co. Md</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond Steagall</b>		24a. REC'D BY REGISTRAR <b>FEB 14 '58</b>	
ADDRESS <b>Thurmont, MD</b>		24b. REGISTRAR'S SIGNATURE <b>John Lewis</b>	

TO HOSPITAL  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4  
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31 JROMITJAS-ITAJAH TO THE MICA 180 EAST CHAUVIN

BUREAU V. S.

FEb 14 1963

REGELIV ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1969 CERTIFICATE OF DEATH

Reg. Dist. No. 11966

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN lb Since 2/20/58	b. COUNTY Frederick	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frederick-Rural RD#3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital	d. STREET ADDRESS Near Yellow Springs	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First NORMAN	Middle LEWIS	Last DUTROW, SR.
4. DATE OF DEATH	Month February	Day 25,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 13 Aug 1890
9. AGE (In years at birthday) 67 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Granville M. Dutrow		
14. MOTHER'S MAIDEN NAME Julia E. Hildebrand	15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] If yes, give war or dates of service No		
16. SOCIAL SECURITY NO. 219-36-4223	17. INFORMANT Mrs. Mary C. Dutrow (Same as item #2)	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)  350 X DUE TO Paralysis agitans			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1948, to Feb. 25, 1958, that I last saw the deceased alive on Feb 25, 1958, and that death occurred at 1:15A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. F. Kline		ADDRESS (Street, city or town, state) M.D. 7 N. Market St., Frederick, Md. DATE SIGNED 2-26-58	
PHYSICIAN'S NAME (Type) H. F. Kline, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-28-58	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE FEB 28 '58	24b. REGISTRAR'S SIGNATURE A. Etchison

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF EDUCATION—BALTIMORE, MD

# BUREAU V

EB. 28.83

**KLEGELIV ED**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01967

Reg. Dist. No.

1970

1. PLACE OF DEATH o. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		b. COUNTY <b>FREDERICK</b>				
c. LENGTH OF STAY IN 1b <b>DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X LIBERTY TOWN</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <b>JESSIE</b>	Middle <b>MAY</b>	Last <b>Eader</b>			
4. DATE OF DEATH	Month <b>Feb.</b>	Day <b>22</b>	Year <b>1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 5 - 1893</b>			
9. AGE (In years last birthday) <b>64 yrs.</b>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>			
13. FATHER'S NAME <b>CHARLES M EADER</b>	14. MOTHER'S MAIDEN NAME <b>IDA SHEETENHELM</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>EDNA E SMITH</b>	Address <b>LIBERTYTOWN MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>(a) Hemiplegia, rt</b> DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Hour <b>o. 31.</b>	Month <b>Feb.</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>LIBERTYTOWN</b>	(County) <b>MD</b>	(State) <b>MD</b>
21. I certify that I attended the deceased from <b>Feb. 20</b> , 1958, to <b>21</b> , 1958, that I last saw the deceased alive on <b>Feb. 21</b> , 1958, and that death occurred at <b>9:50 AM</b> , from the causes and on the date stated above.						
ACTUAL SIGNATURE <b>Bernard O. Thomas</b>	M.D.			ADDRESS (Street, city or town, state) <b>228 N Market St. Frederick, Md</b>		
DATE SIGNED <b>Feb. 22, 1958</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/24/58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>FAIRMOUNT</b>		22d. LOCATION (City, town, or county) <b>LIBERTYTOWN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DD Hartley &amp; Sons, Liberytown Md</b>			ADDRESS	24a. REC'D BY REGISTRAR <b>Feb 25 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Dee Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU V. S.

FEB 25 1959

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01968

Reg. Dist. No.

**1971**

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	c. LENGTH OF STAY IN 1b <b>Years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>31 Winchester Street</b>		d. STREET ADDRESS <b>31 Winchester Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Also known by middle name) (Type or print) <b>Eugene</b> <b>Frederick</b> <b>Elsroad</b>		4. DATE OF DEATH Month <b>February</b> Day <b>17</b> , Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11 June 1893</b>
		9. AGE (In years last birthday) <b>64</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fertilizer</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Wesley Elsroad</b>		14. MOTHER'S MAIDEN NAME <b>Victoria V. Hahn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>220-10-5166</b> 17. INFORMANT Address <b>Howard S. Fink, 27 N. Court St., Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (b) (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH Minutes			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B. O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>2-19-58</b>
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-21-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	24a. REC'D BY REGISTRAR <b>1582050</b>
			24b. REGISTRAR'S SIGNATURE <b>1582050</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to removal.

U.S. GOVERNMENT PRINTING OFFICE: 1917  
WITNESSED CERTIFICATE OF DEATH

BUREAU V. 1

FEB 26 1933

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1972 CERTIFICATE OF DEATH

Reg. Dist. No. 01969

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>18 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>106 West Third Street</b>				d. STREET ADDRESS <b>106 West Third Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>JAMES</b>	Middle <b>CRAWFORD</b>	Last <b>EWING</b>	4. DATE OF DEATH <b>February 23, 1958</b>	Month Day Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 July 1875</b>	9. AGE (In years last birthday) <b>02</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mechanical Engineer</b>		11. BIRTHPLACE (State or foreign country) <b>Rhode Island</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Ewing</b>		14. MOTHER'S MAIDEN NAME <b>Jessie Primrose</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Mina A. Ewing (Same as item #1)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO <b>177X</b> INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cancerous of Prostate</b> DUE TO <b>2 yrs</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month <b>19</b>	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4 W. 3rd St., Frederick, Md.</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 1, 1958</b> , to <b>Feb 23, 1958</b> , that I last saw the deceased alive on <b>Feb 23, 1958</b> , and that death occurred at <b>12:15 P.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>4 W. 3rd St., Frederick, Md.</b> DATE SIGNED <b>2-24-58</b>							
ACTUAL SIGNATURE <b>Thomas E. Stone</b>							
PHYSICIAN'S NAME (Type) <b>Thomas E. Stone, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-26-58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Frederick Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Me. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 25 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Etchison</b>	

EEB 25 1958

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THE GENEVIEVE

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 01970

1. PLACE OF DEATH o. COUNTY Frederick		2. 2007 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE North Carolina b. COUNTY Buncombe	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont-Rural		c. LENGTH OF STAY IN 1b Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Asheville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Catoctin Furnace		d. STREET ADDRESS 18½ East Chestnut Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EARNEST	Middle LEE	Last FARR	4. DATE OF DEATH	Month February 10, Day Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 14 April 1914	9. AGE (In years 43 at birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking Co.		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 410-09-0221		17. INFORMANT Address Paul Worley, Marshall, N. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 823X DUE TO Internal hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO rupture of liver Fractured ribs on left right side } bone (c) Fracture of both legs & rt thigh }					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Instructor ran in stone wall					
20c. TIME OF INJURY Month, Day, Year Hour 5:30 o. m. 2/10 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Route 15 Catoctin Furnace Frederick Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	<i>B. O. Thomas</i>			DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2-11-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 2-11-58	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS M. R. Etchison & Son, Frederick, Maryland	22d. LOCATION (City, town, or county) (State) Marshall, North Carolina		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland	24a. REC'D BY REGISTRAR FEB 13 '58	24b. REGISTRAR'S SIGNATURE <i>Albert E. Schuch</i>			

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

FEB 18 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1973

## CERTIFICATE OF DEATH

Reg. Dist. No.

01971

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.F.D.#4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>Prospect Knoll</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Walter</b>	Middle <b>PAUL</b>	Last <b>Feaga</b>	4. DATE OF DEATH <b>2</b>	Month <b>2</b>	Day <b>16</b>	Year <b>1958</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 9, 1892</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS. Days <b>1</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming&amp;Auto Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm &amp; Auto Sales</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Edward Feaga</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Agnes Unglebower</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-4835</b>		17. INFORMANT <b>Mrs. Maybelle G. Feaga-Same as Item # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anterior壁心臟病</b> DUE TO (c) <b>2 yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/16</b> , 19 <b>58</b> , to <b>2/16</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/16</b> , 19 <b>58</b> , and that death occurred at <b>10 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Henry V Chase</b>				ADDRESS (Street, city or town, state) <b>4 E Church St</b> DATE SIGNED <b>2/16/58</b>			
PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>		M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 20, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick,</b> (State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS 24a. REC'D BY REGISTRAR DATE <b>FEB 19 '58</b> 24b. REGISTRAR'S SIGNATURE <b>G. L. Etchison</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

EEB 19 1953

REGELVÉD

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1974 CERTIFICATE OF DEATH

Reg. Dist. No. 01972

1. PLACE OF DEATH a. COUNTY Frederick, Md.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick, Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, Md.		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, Maryland					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none				d. STREET ADDRESS 376 Madison Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Martha	Middle Ella	Last Free	4. DATE OF DEATH Feb. 18	Month Day	Year 1958		
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept 20, 1871	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 2	Hours Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James A. Richardson		14. MOTHER'S MAIDEN NAME Martha Ella Collins							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	17. INFORMANT Bradley T. Free	Address 376 Madison St. Frederick, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Sanity</u> DUE TO <u>2-3 yrs</u> (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from <u>2-1-</u> , 19 <u>56</u> , to <u>2-18-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-4-</u> , 19 <u>58</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Rex R Martin</u> PHYSICIAN'S NAME (Type) <u>Rex R Martin</u>								ADDRESS (Street, city or town, state) <u>35E Church Frederick, Md.</u>	DATE SIGNED <u>2-18-58</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 22, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Rocky Springs Cemetery	22d. LOCATION (City, town, or county) Frederick Co. Maryland	(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Bailey Jr</u>	ADDRESS <u>1201 3rd Market Fred. Md</u>	24a. REC'D BY REGISTRAR DATE FEB 21 '58	24b. REGISTRAR'S SIGNATURE <u>W. L. Deasch</u>						

BUREAU V.

EB 21 1958

RECEIVED  
MAY 1959

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2008 CERTIFICATE OF DEATH**

11973

Reg. Dist. No.

TO HOSPITAL OR MEDICAL CENTER: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Frederick MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY	
Braddock Heights	6 months	Balto.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Vindobona Convalescent Home	Baltimore 3V01-4		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	Elizabeth	M.	Getzendanner
4. DATE OF DEATH	Month	Day	Year
	February	7	19 58
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
Female	White	Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	5-19-1879
9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
78 yrs.	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Registered Nurse		Maryland	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Milton E. Getzendanner	Clara Smith		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		Mrs. Ed. Grove-Sr.— W. 2nd. St.—Frederick-Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach INTERVAL BETWEEN ONSET AND DEATH 1 year			
151X DUE TO (with metastases liver) 6 months			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 1, 1958, to Feb 7, 1958, that I last saw the deceased alive on Feb 6, 1958, and that death occurred at 12:30 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE	Bernard D. Hinman Jr. M.D.		ADDRESS (Street, city or town, state) Frederick, Maryland DATE SIGNED 2/10/58
PHYSICIAN'S NAME (Type)	Dr. B.O.Thomas-Jr. Professional Bldg.—Frederick—Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-10-1958	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE C.E.Cline & Son	W. ADDRESS Frederick-Md.	24a. REC'D BY REGISTRAR FFR 11 '58	24b. REGISTRAR'S SIGNATURE Quinn

## CERTIFICATE OF DEATH

BUREAU V. S.

FEB 11 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2009 CERTIFICATE OF DEATH

Reg. Dist. No.

01974

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Flinthill</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Flinthill</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Flinthill</b>		d. STREET ADDRESS <b>Rural Rt. 1 Adamstown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Clara</b>	Middle <b>Hellen</b>	Last <b>Gilchrist</b>	4. DATE OF DEATH	Month <b>February</b>	Day <b>6</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH DIVORCED <input type="checkbox"/> <b>Jan. 30-1888</b>	9. AGE (In years (last birthday) <b>69</b> ) yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James F. Lee</b>				14. MOTHER'S MAIDEN NAME <b>Martha Whinns</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-30-7569</b>		17. INFORMANT <b>Charles Franklin Scott</b>		Address <b>Adamstown Rt. 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Renal Vascular Disease</i> DUE TO 44 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		Month Doy Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)  ADDRESS (Street, city or town, state) <i>30 W. All Saints St. Frederick, Md.</i>	(County)	(State)
21. I certify that I attended the deceased from <i>2-16</i> , 19 <i>54</i> , to <i>2-6</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2-5</i> , 19 <i>58</i> , and that death occurred at <i>6: P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE: <i>U.G. Bourne Jr.</i> M.D.							
DATE SIGNED <i>2/1958</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 9-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Fairview</b>		22d. LOCATION (City, town, or county) <b>Frederick, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III Frederick, Md.</b>				ADDRESS <b>30 W. All Saints St. Frederick, Md.</b>		24a. REC'D BY REGISTRAR DATE <i>Feb 10 1958</i>	
						24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

## CERTIFICATE OF DEATH

WITNESS

FEB 10 1968

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1975 CERTIFICATE OF DEATH

01975

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Fred.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ijamsville</b>		d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hosp.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Pamela</b>		First <b>Kaye</b>	Middle <b>Hallman</b>	Last <b>Hallman</b>	4. DATE OF DEATH <b>Feb 11 1958</b>	Month <b>Feb</b>	Day <b>11</b>	Year <b>58</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-12-58</b>	9. AGE (In years last birthday) yrs. <b>2</b>	IF UNDER 1 YEAR Months <b>2</b>	IF UNDER 24 HRS. Days <b>2</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <b>Wayne Augustus Chase</b>		14. MOTHER'S MAIDEN NAME <b>Jane Esther Hallman</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>*****</b>		17. INFORMANT <b>Hospital Records</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Malrotation of intestines</b>									INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frederick</b>		(County) <b>Md.</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>2-12-58</b> , 19 to <b>2-14-58</b> , 19, that I last saw the deceased alive on <b>2-11-58</b> , 19, and that death occurred at <b>4 p</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>J.H. Heldrich</b> M.D.									ADDRESS (Street, city or town, state) <b>Frederick, Md.</b>	DATE SIGNED
PHYSICIAN'S NAME (Type) <b>F.J. Heldrich, M.D.</b>		Frederick Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-15-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Fairview</b>		22d. LOCATION (City, town, or county) <b>Frederick, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III</b>		ADDRESS <b>Frederick, Md.</b>		24a. REC'D BY REGISTRAR <b>Feb 25 '58</b>			24b. REGISTRAR'S SIGNATURE <b>Aspinwall</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

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FEB 25 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1976 CERTIFICATE OF DEATH

Reg. Dist. No. 111976

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE										
<i>Frederick</i>		b. COUNTY										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b										
<i>Rural Frederick</i>		3 hrs.										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS										
<i>Frederick Memorial Hospital</i>												
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year				
<i>Ella</i>		<i>Lavinia</i>	<i>Harshman</i>	<i>Feb</i>	<i>12</i>	<i>1958</i>						
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
<i>F</i>		<i>W</i>		<i>Jan. 1, 1891</i>	<i>67 yrs.</i>	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
<i>Housewife</i>					<i>Maryland</i>		<i>USA</i>					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address								
<i>Josiah Burrier</i>		<i>Lavinia LONG</i>		<i>Harry H. Harshman New Market</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH						
(If yes, give war or dates of service)						<i>Acute coronary thrombosis</i>					<i>3 days</i>	
No												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO										
<i>420.0</i>		<i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</i>		<i>(b)</i>		<i>Arteriosclerotic Heart disease</i>					<i>1 yr +</i>	
DUE TO												
				<i>(c)</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											19. WAS AUTOPSY PERFORMED?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
19												
21. I certify that I attended the deceased from <i>2/12/58</i> , 19 <i>58</i> , to <i>2/12/58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2/12</i> , 19 <i>58</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.											ADDRESS (Street, city or town, state)	
											DATE SIGNED	
ACTUAL SIGNATURE		<i>Henry V Chase</i>									<i>46 Church St</i>	<i>2/12/58</i>
PHYSICIAN'S NAME (Type)		<i>Henry V. Chase</i>									<i>Frederick Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)				
<i>BURIAL</i>		<i>FEB 15-58</i>		<i>BRETHERTON CEMETERY NO PROVIA</i>		<i>Frederick</i>		<i>Md</i>				
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE						
<i>W. E. Salterer New Market Md</i>												
VS A15 (4) 15M 9/55				DATE <i>FEB 24 '58</i>								

## CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1977

## CERTIFICATE OF DEATH

Reg. Dist. No.

01977

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>50 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 Monroe Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>Frederick</b>	
3. NAME OF DECEASED (Type or print)	First <b>LEWIS</b>	Middle <b>ELMER</b>	Last <b>HEERD</b>
4. DATE OF DEATH <b>February 9, 1958</b>	Month <b>February</b>	Day <b>9</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 21, 1885</b>
			9. AGE (In years lost birthday) <b>72 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool Grinder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brush Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis C. Heerd</b>		14. MOTHER'S MAIDEN NAME <b>Annie M. Schaum</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-2336</b>	
17. INFORMANT <b>Mrs. Mamie G. Heerd, Same as item #1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>Congestive heart failure</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6-2</b> , 19 <b>50</b> , to <b>2-9</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-8</b> , 19 <b>58</b> , and that death occurred at <b>8:15A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. West All Saints Street</b>			
ACTUAL SIGNATURE <b>G. Bourne Jr.</b>		DATE SIGNED <b>2/10/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. U. G. Bourne, Jr.</b>		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 12, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick,</b> (State) <b>Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 11 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. E. Etchison</b>	

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BUREAU V. S.

FEB 11 1968

**REGELIV ED**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2010

Items 13, 14, Film G226 3-17-58 et

01978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	Frederick County Carroll Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Route 97 3 miles East of Tayentown		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	DOA Frederick Memorial Hospital		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Elmer	Middle L	Last Hobbs	4. DATE OF DEATH Month Feburary 15 Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Janurary 16, 1886 72 yrs.	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) t ool & die maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Benedict Hobbs		14. MOTHER'S MAIDEN NAME Mary Virginia Ringgold		12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
Elmer H. Hobbs 2512 Moore Ave. Balto. 14				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 824 X DUE TO Fracture base of skull INTERVAL BETWEEN ONSET AND DEATH Minutes				
Conditions, if any, which gave rise to immediate cause (b) DUE TO				
(c) DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Thrown out of car wheels of car ran over neck			
20c. TIME OF INJURY Month, Day, Year How 3 p.m. 2/15/58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 97	20f. (City or town) Nr. Taneytown Carroll Md.	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE B.O.Thomas	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/15/58	
EXAMINER'S NAME (Type) B.O.Thomas, M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 2/20/58	22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Cemetery	22d. LOCATION (City, town, or county) Balto. Co., Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Homes, Balto., Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE FEB 24 '58	24b. REGISTRAR'S SIGNATURE DeL. esch	

BUREAU V.

FEb 24 1958

REGELY ED

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME  
SM 2/57

# MARYLAND STATE DEPARTMENT OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH, 18

01979

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Frederick MARYLAND		Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flint Hill Adamstown R.F.D.I.		c. LENGTH OF STAY IN 1b X Flint Hill Adamstown R.F.D.I.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Female		Elba	Christine
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
Female Colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1930 27 yrs. (9. AGE (In years from birthday)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Irving Holland		14. MOTHER'S MAIDEN NAME Catherine Lee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Unknown	
No		17. INFORMANT John Holland Adamstown R.F.D.I., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 670x		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Uterine Hemorrhage	
(b) DUE TO Child Birth			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O.Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED February 1, 1958	
EXAMINER'S NAME (Type) B.O. Thomas			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-4-58	
22c. NAME OF CEMETERY OR CREMATORIAL Hopehill		22d. LOCATION (City, town, or county) Frederick Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks 111 Frederick-Md.		24a. REC'D BY REGISTRAR FEB 13 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>A. B. Smith</i>	
DATE			

WISCONSIN STATE BOARD OF MEDICAL EXAMINERS • 6801

BUREAU V. S.

1958 FEB 10

RECEIVE

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1978 CERTIFICATE OF DEATH

01980

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Frederick MARYLAND		Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)	c. LENGTH OF STAY IN 1b. 4 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frederick-Rural-R.D.#3	
Frederick d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS Bloomfield	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First CLAUDE	Middle STANLEY	Last HOLTZ
4. DATE OF DEATH	Month February	Day 12,	Year 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	September 10, 1891
9. AGE (In years lost birthday) yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
63	Laborer	Farm	USA Maryland
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Granville C. Holtz	Addie Wachter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes WWI	None	Mr. Carl E. Holtz, Frederick R. F. D. #3, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
904.7 Bronchitis Pneumonia			
DUE TO Shock			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO Fracture Hip			
INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in nursing home			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing home	20f. (City or town) (County) (State) Fredk Co
19			
21. I certify that I attended the deceased from Feb 8, 1957, to Feb 12, 1957, that I last saw the deceased alive on 19, and that death occurred at 7:15 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE	M.D. East Church Street, Frederick, Maryland		
DATE SIGNED 2/14/58			
PHYSICIAN'S NAME (Type) Dr. E. P. Thomas, Sr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 15, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Zion Cemetery	22d. LOCATION (City, town, or county) (State) Frederick County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			
24a. REC'D. BY REGISTRAR FEB 14 '58		24b. REGISTRAR'S SIGNATURE W. L. Etchison	
VS A15 (4) 15M 9/55			



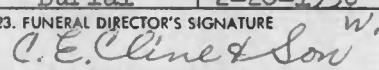
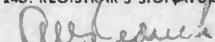
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01981

1979

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick MARYLAND		o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b 41 years		d. STREET ADDRESS 241 West Patrick Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 241 West Patrick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jesse		First Middle Jacob	4. DATE OF DEATH Month February Day 23 Year 1958
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 29-1875
9. AGE (In years lost birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman	
11. KIND OF BUSINESS OR INDUSTRY Electric Railway		12. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Gideon Hoover		14. MOTHER'S MAIDEN NAME Frances Main	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-5999-A	
17. INFORMANT Mrs. Jesse J. Hoover-241 W. Patrick St.		Address Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)  DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1942 to Feb 21, 1958, that I last saw the deceased alive on Feb 21, 1958, and that death occurred at 3:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE  M.D.			
PHYSICIAN'S NAME (Type) Dr. H. F. Kline		ADDRESS 7 North Market Street, Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-1958	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Frederick-Maryland	
24a. REC'D BY REGISTRAR DATE SEP 27 '58		24b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## WASHINGTON STATE GOVERNMENT OF WASHINGTON

## CERTIFICATE OF DEATH

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
EDWARD R. HARRIS	62	MALE	HEART DISEASE
ADDRESS	STREET	CITY	STATE
1111 11th Street	Seattle	Washington	WA
NAME AND ADDRESS OF DOCTOR	STREET	CITY	STATE
DR. JAMES M. HARRIS	1111 11th Street	Seattle	WA
NAME AND ADDRESS OF FUNERAL DIRECTOR	STREET	CITY	STATE
WILLIAM H. HARRIS	1111 11th Street	Seattle	WA
DATE OF DEATH	TIME	AGE	WEIGHT
2/27/58	10:00 AM	62	160 lbs
NAME OF PERSON FILING CERTIFICATE	STREET	CITY	STATE
EDWARD R. HARRIS	1111 11th Street	Seattle	WA
RELATIONSHIP TO DECEASED	STREET	CITY	STATE
SPOUSE	1111 11th Street	Seattle	WA
NAME OF ATTORNEY	STREET	CITY	STATE
WILLIAM H. HARRIS	1111 11th Street	Seattle	WA
RECEIVED	RECEIVED	RECEIVED	RECEIVED
BUREAU X-5	FEB 27 1958		

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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WISCONSIN STATE DEPARTMENT OF MORTALITY-EXAMINERS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED V. S.

DEPT. 13 1958

RECEIVED

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1981 CERTIFICATE OF DEATH

Reg. Dist. No.

01983

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Frederick MARYLAND		Maryland Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY	
Frederick	Since 1/30/58	X Mount Airy Rural RD#3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
Frederick Memorial Hospital	Plane #1		
3. NAME OF DECEASED (Type or print)	MORIELL First I. Middle JONES Lost	4. DATE OF DEATH	Month Day Year
	Moriell I. JONES	Feb.	2 1958
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
M	W		Unknown
9. AGE (In years lost birthday) 62? yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. KIND OF BUSINESS OR INDUSTRY Farming	12. BIRTHPLACE (State or foreign country) Maryland
IF UNDER 1 YEAR Months Days Hours Min.	13. CITIZEN OF WHAT COUNTRY? USA		
14. FATHER'S NAME Charles E. Jones		14. MOTHER'S MAIDEN NAME Annie Purdum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Edward M. Smith, Frederick, Md.	221 Center St.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH } 3-4 days	
(b) Venous thrombosis			
(c) Arteriosclerotic heart disease, decompensated		Prob. sev. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from Jan. 30, 1958, to Feb 2, 1958, that I last saw the deceased alive on Feb 1, 1958, and that death occurred at 2 <sup>nd</sup> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph L. Michels M.D.			ADDRESS (Street, city or town, state) New Market, Maryland DATE SIGNED 2/2/58
PHYSICIAN'S NAME (Type) Ralph L. Michels MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-5-58	22c. NAME OF CEMETERY OR CREMATORIUM Providence Cemetery	22d. LOCATION (City, town, or county) (State) Kemptown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE FEB 6 '58	24b. REGISTRAR'S SIGNATURE

## CERTIFICATE OF DEATH

BUREAU V. S.

FEB 6 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2012 CERTIFICATE OF DEATH

Reg. Dist. No.

01984

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg,</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg,</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>DePaul Street</b>		d. STREET ADDRESS <b>DePaul Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>John</b>		First	Middle <b>Francis</b>	Last <b>Kelly</b>	4. DATE OF DEATH <b>February 17, 1958</b>	Month	Day	Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 28, 1871</b>	9. AGE (In years last birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months <b>86</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Broom maker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Jerome F. Kelly</b>		14. MOTHER'S MAIDEN NAME <b>Mary Peddicord</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-30-5733</b>		17. INFORMANT <b>Alice G. Kelly</b>		Address <b>Emmitsburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		<b>coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Emmitsburg, Md.</b>		(State)	
21. I certify that I attended the deceased from <b>Feb 22</b> , 1958, to <b>Feb 17</b> , 1958, that I last saw the deceased alive on <b>Feb 6</b> , 1958, and that death occurred at <b>6:40 P.M.</b> from the causes and on the date stated above.							ADDRESS (Street, city or town, state) <b>Emmitsburg, Md.</b>		DATE SIGNED <b>2-18-58</b>
ACTUAL SIGNATURE <b>Charles R. Williams</b>		M.D.							
PHYSICIAN'S NAME (Type) <b>CHARLES R. WILLIAMS</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/20/1958</b>		22c. NAME OF CEMETERY OR Crematory <b>St. Joseph's Catholic</b>		22d. LOCATION (City, town, or county) <b>Emmitsburg, Frederick Co. Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Allison</b>		ADDRESS <b>Emmitsburg, Md.</b>		24a. REG'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01985

1. PLACE OF DEATH a. COUNTY <b>Frederick County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>628 Grant Place</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hosp.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MINNA</b>	Middle <b>FAUL</b>	Last <b>KNOLL</b>	4. DATE OF DEATH <b>Feb. 4, 1958</b>	Month <b>Feb.</b>	Day <b>4,</b>	Year <b>1958</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1886</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months <b>71</b>	IF UNDER 24 HRS. Days <b>71</b>	Hours <b>71</b>		
10a. USUAL OCCUPATION (Give kind of work done during most at working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Alfred J. Faul</b>		14. MOTHER'S MAIDEN NAME <b>Minna Caspari</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
				<b>Mr. Alfred J. Knoll - 628 Grant Pl., Frederick Md</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>									
443X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from <b>11-1-</b> , 19 <b>55</b> , to <b>2-3-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-3-</b> , 19 <b>58</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.								ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <b>Rex R Martin</b>								DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Rex R Martin</b>								<b>Frederick Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/7/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cem.</b>			22d. LOCATION (City, town, or county) <b>Baltimore Md.</b>			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Vickery &amp; Sons - Baltimore</b>	ADDRESS <b>1717 N. Charles St.</b>	24a. REC'D BY REGISTRAR <b>FEB 6 '58</b>			24b. REGISTRAR'S SIGNATURE <b>Reuben</b>				

**BUREAU**

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**REGELEY ED**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1983 CERTIFICATE OF DEATH

Reg. Dist. No. 01986

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Memorial Hospital		e. STREET ADDRESS Mountville Road	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle EDWARD Last LAMM		4. DATE OF DEATH Month February Day 2, Year 1958	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH 23 Oct 1874	9. AGE (In years lost birthday) 83 yrs.
			IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Solomon Lamm		14. MOTHER'S MAIDEN NAME Henrietta Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-8146 17. INFORMANT Mrs. Mary E. Lamm (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if lost.  (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
Pulmonary & Generalized Edema		3 mo	
Myocarditis Decompensated		2 yrs	
Generalized Atherosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>57</u> , to <u>Feb 2, 1958</u> , that I last saw the deceased alive on <u>Feb 1, 1958</u> , and that death occurred at <u>5:30A</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Jefferson, Md. DATE SIGNED 2-4-58	
ACTUAL SIGNATURE <u>A. T. Brice</u> PHYSICIAN'S NAME (Type) A. T. Brice, M. D.		22. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2-5-58 22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery 22d. LOCATION (City, town, or county) Jefferson, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR FEB 6 '58	24b. REGISTRAR'S SIGNATURE

## CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Name of Physician

Name of Hospital

BUREAU V. S.

FEB 6 1978

REG'D V.E.D.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2913 CERTIFICATE OF DEATH

01987

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write name of town) Knoxville		c. LENGTH OF STAY IN 1b - X	
d. NAME OF HOSPITAL (If not in hospital, give street address) Knoxville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville	
3. NAME OF DECEASED (Type or print) First Gertrude Middle - Last Lewis		4. DATE OF DEATH Feb. Month 17 Day Year 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1878
9. AGE (In years last birthday) yrs. 79		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Weverton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Harrison		14. MOTHER'S MAIDEN NAME Caroline (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Albert Miller		Address Knoxville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x <i>Gertrude</i>		INTERVAL BETWEEN ONSET AND DEATH 1 week	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Hypertension</i> (c) <i>Hypertension</i>		10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/1/18</u> , 19 <u>57</u> , to <u>2/17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/12</u> , 19 <u>58</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. B. Blueprinter</i>		ADDRESS (Street, city or town, state) <i>Lovettsville, Va.</i> DATE SIGNED <u>2/18/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <u>Feb. 19</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Reformed</i>		22d. LOCATION (City, town, or county) <u>Knoxville, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Eloa J. Feete</i>		24a. REC'D BY REGISTRAR ADDRESS <u>Brunswick, Md.</u> DATE <u>FEB 24 '58</u>	
		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1984

## CERTIFICATE OF DEATH

01988

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Frederick MARYLAND		Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Frederick	51 years	Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
206 East 6th Street		206 East 6th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	Gertie	Emma	Lipps
4. DATE OF DEATH	Month	Day	Year
	February	19th	19 58
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
Female	White	WIDOWED <input checked="" type="checkbox"/> *REX R MARTIN	Sept. 22-1879
9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
78 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife		Own Home	Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Claggett Albert Waltz		Sarah Elizabeth Ernst	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		None	Mr. Maynard V. Lipps-206 E. 6th St.-Frederick-Md.
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
331X Cerebral vascular accident INTERVAL BETWEEN ONSET AND DEATH 3 years			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b)			
Senility 5 yrs.			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Nat white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from March 10, 1955, to Feb 19, 1958, that I last saw the deceased alive on Feb 18, 1958, and that death occurred at 2:30 A.M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE		M.D. 35 E. Church Frederick MD 2-19-58	
PHYSICIAN'S NAME (Type)		Rex R Martin	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	2-22-1958	Nt. Olivet Cemetery	Frederick-Maryland
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE	
W. C. E. Cline & Son		FEB 21 '58	
		24b. REGISTRAR'S SIGNATURE	
		Albert J. Cline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG226 2-28-58 et

## CERTIFICATE OF DEATH

01989

Reg. Dist. No.

2014

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Ijamsville</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Riggs Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sabillisville</b>			
f. STREET ADDRESS <b>rural</b>		g. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Lorene V Lohr</b>	Middle	Last		
4. DATE OF DEATH	Month <b>Feb</b>	Day <b>16</b>	Year <b>1958</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1886 Nov. 12, 1886</b>		
9. AGE (In years less birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife-Nurse</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Illinois-(Mantena)</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Henry Mortimer</b>	14. MOTHER'S MAIDEN NAME <b>Susan Montague</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT <b>Dr. Gerald M. Isbell</b>	Address <b>Baltimore, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yrs</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>420.0</b>					
(b) DUE TO <b> </b>					
(c) DUE TO <b> </b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b> </b>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b> </b>	20f. (City or town) <b> </b>	(County) <b> </b>	(State) <b> </b>
21. I certify that I attended the deceased from <b>Feb 4, 1958</b> , to <b>Feb 16, 1958</b> , that I last saw the deceased alive on <b>Feb 10, 1958</b> , and that death occurred at <b>4:00 P.M.</b> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <b>Ijamsville MD</b>				
ACTUAL SIGNATURE <i>Joseph Lerner</i>	DATE SIGNED <b>Feb 16 58</b>				
PHYSICIAN'S NAME (Type) <b>Joseph Lerner M.D.</b>					
22a. BURIAL, CREMATION, BURNING (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Feb. 21, 1958</b>	22c. NAME OF CEMETERY OR Crematory <b>Park Heights Cemetery</b>	22d. LOCATION (City, town, or county) <b>Brinsford, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Eloard Feete</i>	ADDRESS <b>Brunswick, Md.</b>	24a. REC'D BY REGISTRAR <b>Feb 24 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Alfred Beach</i>		

## MUNICIPAL STATE GOVERNMENT OF HAITI - SANDBERG &amp; R

## CERTIFICATE OF DEATH

NAME	SEX	AGE	DEATH DATE
ADDRESS	STATE	CITY	ZIP
CAUSE OF DEATH			
DEATH CERTIFICATION			
EXAMINER'S SIGNATURE			
BUREAU Y. S.			
FEB 24 1958			
RECEIVED			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1985 CERTIFICATE OF DEATH

Reg. Dist. No.

01990

**TO HOSPITAL** or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>6 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>113 E. 5th Street</b>		d. STREET ADDRESS <b>113 E. 5th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>Hayes</b>	Last <b>Luby</b>	4. DATE OF DEATH Feb. 8 1958	Month Feb.	Day 8	Year 1958
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9- 1885</b>	9. AGE (In years less than birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Lime Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John W. Luby</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Freeland</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-0737</b>		17. INFORMANT <b>Vannie E. Luby--113 E. 5th Street Fred. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chremia</b>		DUE TO <b>444 X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>My months</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Essential hypertension</b>		DUE TO (c) _____		Years -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>218</b>	(County) <b>1958</b>		
21. I certify that I attended the deceased from <b>2/7</b> , 1958, to <b>2/8</b> , 1958, that I last saw the deceased alive on <b>2/7</b> , 1958, and that death occurred at <b>M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James B. Thomas</b>	ADDRESS (Street, city or town, state) <b>228 N. Market St - Frederick, Md.</b>		DATE SIGNED <b>Feb. 14 '58</b>				
PHYSICIAN'S NAME (Type) <b>James B. Thomas</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 11-58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Fairview</b>	22d. LOCATION (City, town, or county) <b>Frederick, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks</b>		ADDRESS <b>111 Frederick, Md.</b>	24a. REC'D BY REGISTRAR <b>Feb 14 '58</b>	24b. REGISTRAR'S SIGNATURE <b>One Finch</b>			

WISCONSIN STATE DEPARTMENT OF HEALTH—SANITATION

CERTIFICATE OF DEATH

BUREAU X.

FEB 14 1928

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**1986 CERTIFICATE OF DEATH**

01991

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>7 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>134 West Patrick Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>MARY</b>	Middle <b>ANN</b>	Last <b>MILYARD</b>	4. DATE OF DEATH Month <b>February</b>	Day <b>15,</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1883</b>	9. AGE (In years last birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Adam Bell</b>				14. MOTHER'S MAIDEN NAME <b>Jane Elizabeth Murphy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Gordon H. Milyard-Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> 464X DUE TO <b>Thromboflebitis</b> UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frederick</b>	(County) <b>Maryland</b> (State)
21. I certify that I attended the deceased from <b>2/10, 1958</b> , to <b>2/15, 1958</b> , that I last saw the deceased alive on <b>2/15, 1958</b> , and that death occurred at <b>4:25 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>James B. Thomas</i>				ADDRESS (Street, city or town, state) <b>M.D. Professional Building, Frederick, Maryland</b> DATE SIGNED <b>2/18/1958</b>			
PHYSICIAN'S NAME (Type) <b>Dr. James B. Thomas</b>		Frederick, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 19, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS DATE <b>FEB 19 '58</b> 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <i>A. Etchison</i>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

See below

Name of deceased		Name of physician	
John J. O'Leary		John J. O'Leary	
Age		Cause of death	
50 years		Diseased heart	
Sex		Place of death	
Male		At home	
Race		Date of death	
White		Feb 19, 1938	
Occupation		Time of death	
Retired		12:00 P.M.	
Residence		Method of death	
Baltimore, Md.		Natural death	
Employer		Name of hospital	
Name and address of physician		Signature of physician	
John J. O'Leary 100 W. Pratt Street Baltimore, Md.		John J. O'Leary	
Name and address of coroner		Signature of coroner	
Name and address of medical examiner		Signature of medical examiner	
Name and address of funeral director		Signature of funeral director	
Name and address of reporter		Signature of reporter	
BUREAU V. S. FEB 19 1938		RECEIVED	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1987

## CERTIFICATE OF DEATH

Reg. Dist. No.

11992

1. PLACE OF DEATH a. COUNTY <u>Frederick</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		d. STREET ADDRESS <u>548 East Church St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>James</u>	Middle <u>Brooke</u>	Last <u>Parkinson</u>	4. DATE OF DEATH <u>Feb</u>	Month <u>19</u>	Day <u>19</u>	Year <u>1958</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Feb. 17, 1958</u>	9. AGE (In years last birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u>	IF UNDER 24 HRS. Days <u>2</u>	Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin Brooke Parkinson Jr</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Anne Aeschbachur</u>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/15/58</u> , 19 <u>58</u> , to <u>1/19/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/15/58</u> , 19 <u>58</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>220 N. Market St</u>				DATE SIGNED <u>2-19-58</u>	
ACTUAL SIGNATURE <u>A.M. Powell Jr</u>		M.D.					
PHYSICIAN'S NAME (Type) <u>A.M. Powell, M.D.</u>		FREDERICK - MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-1958</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) <u>Frederick - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Cline &amp; Son</u>		ADDRESS <u>Frederick - Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

## CERTIFICATE OF DEATH

DEATH CERTIFICATE

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
JOHN HENRY COOPER	50	MALE	CHRONIC DISEASE

NAME OF DOCTOR	ADDRESS	NAME OF HOSPITAL	ADDRESS
DR. JAMES M. COOPER	1234 FAIRFIELD DR.	HARVEY HOSPITAL	1234 FAIRFIELD DR.

TIME OF DEATH	DATE OF DEATH	TIME OF AUTOPSY	DATE OF AUTOPSY
10:00 AM	APRIL 12, 1953	10:00 AM	APRIL 12, 1953

TIME OF DEATH	DATE OF DEATH	TIME OF AUTOPSY	DATE OF AUTOPSY
10:00 AM	APRIL 12, 1953	10:00 AM	APRIL 12, 1953

TIME OF DEATH	DATE OF DEATH	TIME OF AUTOPSY	DATE OF AUTOPSY
10:00 AM	APRIL 12, 1953	10:00 AM	APRIL 12, 1953

TIME OF DEATH	DATE OF DEATH	TIME OF AUTOPSY	DATE OF AUTOPSY
10:00 AM	APRIL 12, 1953	10:00 AM	APRIL 12, 1953

TIME OF DEATH	DATE OF DEATH	TIME OF AUTOPSY	DATE OF AUTOPSY
10:00 AM	APRIL 12, 1953	10:00 AM	APRIL 12, 1953

TIME OF DEATH	DATE OF DEATH	TIME OF AUTOPSY	DATE OF AUTOPSY
10:00 AM	APRIL 12, 1953	10:00 AM	APRIL 12, 1953

TIME OF DEATH	DATE OF DEATH	TIME OF AUTOPSY	DATE OF AUTOPSY
10:00 AM	APRIL 12, 1953	10:00 AM	APRIL 12, 1953

TIME OF DEATH	DATE OF DEATH	TIME OF AUTOPSY	DATE OF AUTOPSY
10:00 AM	APRIL 12, 1953	10:00 AM	APRIL 12, 1953

TIME OF DEATH	DATE OF DEATH	TIME OF AUTOPSY	DATE OF AUTOPSY
10:00 AM	APRIL 12, 1953	10:00 AM	APRIL 12, 1953

BUREAU Y.

APR 13 1953

FBI BALTIMORE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1988

## CERTIFICATE OF DEATH

01993

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b> and give nearest town <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Jefferson</b>	
		d. STREET ADDRESS <b>Route 1</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Lillian</b>	Middle <b>Lenora</b>	Last <b>Pearl</b>
4. DATE OF DEATH	Month <b>Feb.</b>	Day <b>9th</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>July 6-1901</b>
9. AGE (In years lost birthday) <b>50 yrs.</b>		10. IF UNDER 1 YEAR Months <b>50</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Luther M. Beard</b>		14. MOTHER'S MAIDEN NAME <b>Alice Keeney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-18-1036</b>	
17. INFORMANT <b>Lawrence C. Pearl-Route 1-Jefferson-Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Arteriosclerotic Heart Disease</b>		6 month (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8 Feb</b> , 19 <b>58</b> , to <b>9 Feb</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9 Feb</b> , 19 <b>58</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>J. E. Stone</b> PHYSICIAN'S NAME (Type) <b>Dr. T.E. Stone</b>		ADDRESS (Street, city or town, state) <b>4 W. 3rd. St.</b> DATE SIGNED <b>2-11-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-13-1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>
22d. LOCATION (City, town, or county) <b>Frederick</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 13 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Archibald</b>

## CERTIFICATE OF DEATH

NAME OF DECEASED		AGE	
MATERIALS FOR AUTOPSY		TIME AND PLACE OF DEATH	
CIRCUMSTANCES LEADING TO DEATH		MEDICAL HISTORY	
TESTIMONY		EXAMINATION	
CAUSE OF DEATH		DEATH CERTIFICATE	
RECEIVED		RECEIVED	
BUREAU V.		EB 12 1958	

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1989

## CERTIFICATE OF DEATH

Reg. Dist. No.

01994

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Station Hospital, Fort Detrick</b>				d. STREET ADDRESS <b>235 South Market Street</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALSO KNOWN AS CATHERINE S. PFARR ANNA CATHARINE</b>		Last <b>PFARR</b>		4. DATE OF DEATH Month <b>February</b>		Day Year <b>3, 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 26, 1878</b>	9. AGE (In years lost birthday) <b>79 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse &amp; Technician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew Steiner</b>		14. MOTHER'S MAIDEN NAME <b>Catharine Duecker</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-05-9921A</b>		17. INFORMANT <b>Mrs. Byron A. Winebrenner, Frederick, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH <b>40 Hrs.</b>	
						28 Days	
						?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CYSTITIS, ASPIRATION PNEUMONIA</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 29, 1958</b> , to <b>Feb. 3, 1958</b> , that I last saw the deceased alive on <b>Feb. 3, 1958</b> , and that death occurred at <b>9:17 A.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>Nathan D. Charles</i>						DATE SIGNED <b>2/3/58</b>	
PHYSICIAN'S NAME (Type) <b>Nathan D. Charles M.D. Capt, MC.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 6, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Fort Myer, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>DEB 6 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Deb. Etchison</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU U.S.

FEB 6 1958

DECEASED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1990

## CERTIFICATE OF DEATH

01995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>48 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick County Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marion</b>		First <b>F.</b>	Middle <b>Pomeroy</b>
4. DATE OF DEATH <b>Feb. 27 1958</b>		Lost	Month
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2-1880</b>
9. AGE (In years last birthday) <b>77 yrs.</b>		9. IF UNDER 1 YEAR Months <b>0</b>	10. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Pomeroy</b>		14. MOTHER'S MAIDEN NAME <b>Julia Lochner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-10-8703A</b> 17. INFORMANT <b>Mrs. Marion F. Pomeroy-115 W. South St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yrs.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sensitivity</b>			
DUE TO <b>Generalized arteriosclerosis</b>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-1 1955</b> , to <b>2-27 1958</b> , that I last saw the deceased alive on <b>2-26 1958</b> , and that death occurred at <b>10:00PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>35 E. Church St.</b> DATE SIGNED <b>3-1-58</b>	
ACTUAL SIGNATURE <b>Rex R. Martin M.D.</b>		PHYSICIAN'S NAME (Type) <b>Dr. Rex R. Martin</b> Frederick-Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-3-1958</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick-Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Cline &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 3 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE GOVERNMENT OF MARYLAND - BALTIMORE, MD

CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
MAR 3 1959

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2015 CERTIFICATE OF DEATH**

Reg. Dist. No.

01996

**TO HOSPITAL** or attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) o. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont, Maryland</b>	
3. NAME OF DECEASED (Type or print) <b>William Samuel Pryor</b>		d. STREET ADDRESS <b>Carroll Street</b>	
4. DATE OF DEATH <b>February 8 1958</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Antique shop</b>	
10c. BIRTHPLACE (State or foreign country) <b>Maryland</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wilson L. Pryor</b>		14. MOTHER'S MAIDEN NAME <b>Ida Hauver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>188-09-5190</b>	
17. INFORMANT <b>William S. Pryor, Jr.</b>		Address <b>Thurmont, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 mo.</b>	
153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Carcinoma of descending colon</b>		1 yr.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myocardial ischemia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 2 1957</b> , to <b>Feb. 8 1958</b> , that I last saw the deceased alive on <b>Feb. 8 1958</b> , and that death occurred at <b>3:00 p.m.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b>	
ACTUAL SIGNATURE <b>M. Franklin Birely</b>		DATE SIGNED <b>2/10/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. M. Franklin Birely</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-11-58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>United Brethren Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager Thurmont, Md.</b>		ADDRESS <b>Raymond E. Creager</b>	
		24a. REC'D BY REGISTRAR <b>FEB 13 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>John J. Bauch</b>	

## CERTIFICATE OF DEATH

Date Rec'd

BUREAU V.

CEB 13 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1991 CERTIFICATE OF DEATH

Reg. Dist. No. 01997

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>over 40 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3 Pines Nursing Home</b>				d. STREET ADDRESS <b>16 East South St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Milton</b>	Middle <b>Urner</b>	Last <b>Rickerd</b>	4. DATE OF DEATH Month <b>February</b>	Day <b>6</b>	Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>9-21-1880</b>	9. AGE (In years last birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>shipping clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Wm. H. Rickerd</b>				14. MOTHER'S MAIDEN NAME <b>Catherine L. King</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>214-10-4878</b>		17. INFORMANT <b>Silas T. Rickerd-Frederick-Md. (Brother)</b>		Address		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>INTERVAL BETWEEN ONSET AND DEATH <b>8 mo</b></p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month <b>19</b>	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Frederick</b>	(County)	(State)	
<p>21. I certify that I attended the deceased from <b>1-6 - 1958</b> to <b>2 - 6 1958</b>, that I last saw the deceased alive on <b>1-7 1958</b>, and that death occurred at <b>5:30 P.M.</b>, from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) <b>35 East Church St., Frederick, Md.</b></p> <p>DATE SIGNED <b>2-7-1958</b></p>								
ACTUAL SIGNATURE <i>Rex R. Martin</i>	M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. Rex Martin</b>	35 East Church St., Frederick, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-8-1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick - Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>C E Cline &amp; Son</i>	ADDRESS <b>Frederick-Md.</b>	24a. REC'D BY REGISTRAR <b>DATE FEB 10 1958</b>	24b. REGISTRAR'S SIGNATURE <i>D. J. Cline</i>					

07.09.2018-17:13:39 ИМЯ ПОЛЬЗОВАТЕЛЯ: STAT2 ОНЛАЙН

BUREAU V. S.

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REGGIE EO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1992

## CERTIFICATE OF DEATH

Reg. Dist. No.

01998

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 50 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 406 West South Street				d. STREET ADDRESS 406 West South Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First DELLA	Middle SOPHIA	Last SCHELL	4. DATE OF DEATH February 8, 1958	Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 June 1886	9. AGE (In years at birthday) 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Randolph Hamilton				14. MOTHER'S MAIDEN NAME Anna Maria Hartman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Nellie L. Gaugh (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ch. Cardiac Arrest</i>						INTERVAL BETWEEN ONSET AND DEATH <i>8 3/4</i>	
442X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		DUE TO					
{ DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>30 W. All Saints St., Fred'k, Md.</i>	(County) (State)
21. I certify that I attended the deceased from <i>4-5</i> , 19 <i>57</i> , to <i>2-8</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2-7</i> , 19 <i>58</i> , and that death occurred at <i>9 A</i> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>M.D.</i>		DATE SIGNED <i>2-10-58</i>	
ACTUAL SIGNATURE <i>U. G. Bourne Jr.</i>							
PHYSICIAN'S NAME (Type) U. G. Bourne, Jr., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-11-58		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>FEB 11 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Rehersch</i>	

## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

BUREAU V. S.

23 11 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1993

## CERTIFICATE OF DEATH

Reg. Dist. No. 1999

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>CARRUGH</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>		d. STREET ADDRESS <b>ELGER ST.</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>MAGGIE</b>	Middle <b>BELLIE</b>	Last <b>SELBY</b>	4. DATE OF DEATH <b>FEB. 9</b>	Month Year <b>1958</b>	Day	Year			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 8 - 1880</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>WESLEY WILSON</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN HILTEBRIDGE</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>RALPH C SELBY - BALTIMORE MD</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <i>Coronary thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) (c)		DUE TO <i>420.1</i>								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>UNION TOWN</b>		(County) <b>MONTGOMERY</b>	(State) <b>M.D.</b>	
21. I certify that I attended the deceased from <b>Feb. 5, 1958</b> to <b>Feb. 9, 1958</b> , and that death occurred at <b>2:40 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>UNION BRIDGE MONTGOMERY M.D.</b>							DATE SIGNED <b>Feb. 9, 1958</b>	
ACTUAL SIGNATURE <b>T. H. MESSLER, M.D.</b>		M.D.								
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/12/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>LUTHERAN</b>		22d. LOCATION (City, town, or county) <b>UNION TOWN</b>		(State) <b>M.D.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. Hartley &amp; Sons Union Bridge Sud</b>		ADDRESS							24a. REC'D BY REGISTRAR DATE <b>FEB 13 '58</b>	
									24b. REGISTRAR'S SIGNATURE <b>A. L. Smith</b>	

TO HOSPITAL OR HOMECARE: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU V. S.

FEB 13 1938

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1994

## CERTIFICATE OF DEATH

02000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 11/56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland Odd Fellows Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) First GEORGE Middle W. Last SHEELEY		4. DATE OF DEATH February 13, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5 May 1871
			9. AGE (In years last birthday) 80 yrs.
			IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Knitting Mills	11. BIRTHPLACE (State or foreign country) Maryland
		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Sheeley		14. MOTHER'S MAIDEN NAME Katherine Kohler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-18-7241	17. INFORMANT Maryland Odd Fellows Home, (Same as item #1)
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  331X		1 DAY	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b) <i>Cerebral Hemorrhage</i> (c) <i>Arteriosclerosis</i>		10 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 12, 1958, to Feb. 13, 1958, that I last saw the deceased alive on Feb. 13, 1958, and that death occurred at 11:30P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Wm. M. Smith</i> M.D. 4 E. Church St., Frederick, Md. 2-15-58 DATE SIGNED	
PHYSICIAN'S NAME (Type) William M. Smith, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-17-58	22c. NAME OF CEMETERY OR CREMATORIUM Stauffers Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		22d. LOCATION (City, town, or county) Smithsburg, Maryland (State)	24a. REC'D. BY REGISTRAR FEB 17 1958 DATE
		24b. REGISTRAR'S SIGNATURE <i>W. Redden</i>	

## CERTIFICATE OF DEATH

1950

BUREAU V. S.

FEB 18 1953

RECEIVED

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
· MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02001

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PMJ. Page 5 may be retained for files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit.—File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. AT5ME  
5M 2/57

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		1995		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		b. COUNTY Carroll	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Windsor</b>		f. STREET ADDRESS <b>Chirch Street</b>	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Thomas</b>	Middle <b>CROMWELL</b>	SLINGLUFF	DATE OF DEATH Feburary 17 1958
4. SEX <b>Male</b>		5. COLOR OR RACE <b>White</b>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 21, 1862</b>
9. AGE (In years less birthday) <b>95 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired FARMER</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>LOUIS P SLINGLUFF</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET CROMWELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>ROBERT SLINGLUFF NEW WINDSOR</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Address <b>RURAL MD.</b>			
<b>443X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		Pulmonary Edema & congestive heart failure	
		DUE TO (c)		Sclerotic heart disease	
				5 yrs.	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>		(County) <b>MARYLAND</b>		(State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>B.O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>February 17, 1958</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/20/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>PIPE GREEK CEM CARROLL COUNTY MD</b>	
22d. LOCATION (City, town, or county) <b>MD</b>		(State)			
22e. FUNERAL DIRECTOR'S SIGNATURE <i>D. D. Hackley &amp; Sons, New Windsor MD</i>		ADDRESS		24a. REC'D BY REGISTRAR <b>FEB 20 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>W. E. Edwards</i>	

STATE OF HAWAII  
DEPARTMENT OF HEALTH - DIVISION OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU N.Y.

FEB 20 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1996

## CERTIFICATE OF DEATH

Reg. Dist. No. 112002

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>7 HRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Edith</b>	Middle <b>Irene</b>	4. DATE OF DEATH Month <b>2</b> Day <b>21</b> Year <b>1958</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 20 - 1918</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>
13. FATHER'S NAME <b>BOOKER STOUT</b>		14. MOTHER'S MAIDEN NAME <b>MAGGIE HART</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>CLEVE V SMITH</b>
			Address <b>RURAL NEW WINDSOR MD</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/21/58</b> , to <b>2/21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/21</b> , 19 <b>58</b> , and that death occurred at <b>7:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Henry V Chase</b> M.D. <b>4 E. Church St</b> <b>2/22/58</b> PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b> <b>Fredrick Maryland</b>			
22o. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/25/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>PREMIER CEMETARY PREMIER</b>	22d. LOCATION (City, town, or county) <b>W. VA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>DD Hartzler &amp; Sons</b>	ADDRESS <b>New Windsor, Md</b>	24a. REC'D BY REGISTRAR <b>FEB 22 1958</b>	24b. REGISTRAR'S SIGNATURE <b>Dee L. Smith</b>

## CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP

STREET

CITY

STATE

FBI  
BUREAU

3-25-1958

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be readied at the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2016 CERTIFICATE OF DEATH

Reg. Dist. No. 02003

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ladiesburg</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ladiesburg</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Floyd</b>		First <b>Hamilton</b>	Middle <b>Smith</b>	Lost	4. DATE OF DEATH <b>February 27, 1958</b>	Month <b>February</b>	Day <b>27</b>	Year <b>1958</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>November 3, 1886</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles H. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Lippy</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-09-1387</b>		17. INFORMANT <b>Mrs. Elsie Smith, Ladiesburg, Maryland</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>					
<b>Congestive Heart Failure</b>		<b>5 years</b>							
<b>Arteriosclerotic Heart Disease</b>		<b>5 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <b>Pulmonary Emphysema</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Taneytown</b>		(County) <b>Maryland</b>	(State) <b>MD</b>
21. I certify that I attended the deceased from <b>March 1958</b> , to <b>Feb 27, 1958</b> , that I last saw the deceased alive on <b>Feb 14, 1958</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>Taneytown, Maryland</b>	
ACTUAL SIGNATURE <b>E. Ambler Thompson, M.D.</b>								DATE SIGNED <b>2-28-58</b>	
PHYSICIAN'S NAME (Type) <b>Merwyn C. Fuss</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 2, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Haugh's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Ladiesburg, Maryland</b>		(State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b>		ADDRESS <b>Taneytown, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Gedrich</b>			

MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF  
MEDICAL EXAMINER

CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
MAR 3 1968

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2017 CERTIFICATE OF DEATH

Reg. Dist. No.

02004  
13944

1. PLACE OF DEATH o. COUNTY		Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick		Maryland		o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 175 days		b. COUNTY Charles	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		Bel Alton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Harry	Middle Spalding	4. DATE OF DEATH February 25	Month Day Year 1958
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1889	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Edward Leo Spalding		14. MOTHER'S MAIDEN NAME Elizabeth Gattor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 710		16. SOCIAL SECURITY NO. 218-30-3964		17. INFORMANT Records of Victor Cullen State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Far advanced pulmonary tuberculosis</u> DUE TO (c) —				INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cullen, Maryland	(County) (State)
21. I certify that I attended the deceased from <u>9/3, 1957</u> , to <u>2/25/58</u> , 19, that I last saw the deceased alive on <u>2/25/1958</u> , and that death occurred at <u>11:35M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>T. Vestal</u> M.D. <u>Victor Cullen State Hospital</u> ADDRESS (Street, city or town, state) DATE SIGNED					
PHYSICIAN'S NAME (Type) Tom F. Vestal, M.D.		Cullen, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-28-58	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	22d. LOCATION (City, town, or county) <u>Baltimore, Baltimore, Md</u> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard J. Lee</u>		24a. REC'D BY REGISTRAR FEB 27 '58	24b. REGISTRAR'S SIGNATURE <u>Albert E. Smith</u>		

## 11 CERTIFICATE OF DEATH

BUREAU K-5  
FEB 27 1958  
RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2018

## CERTIFICATE OF DEATH

Reg. Dist. No. 12005

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>				MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KNOXVILLE</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X KNOXVILLE</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KNOXVILLE</b>				d. STREET ADDRESS <b>1 KNOXVILLE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First <b>Harry</b>	Middle <b>Lee</b>	Last <b>STEVENS</b>	4. DATE OF DEATH Month <b>Feb.</b>	Day <b>11</b>	Year <b>1958</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>AUG. 17, 1880</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BLACKSMITH</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>BURKITTSVILLE, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William STEVENS</b>				14. MOTHER'S MAIDEN NAME <b>FANNIE House</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Raymond Stevens</b> Address <b>KNOXVILLE, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Lat Central Maryland</b> c 29 L Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Lat. bonygia -</b> (c) <b>Gangrene asthmaticus -</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>2-10-1958</b>	(County) 2-11-1958	
21. I certify that I attended the deceased from <b>alive on 2-11-1958</b> and that death occurred <b>on 2-10-1958</b> to <b>2-11-1958</b> at <b>LOCUST VALLEY</b> , M., from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>John W. Fute</b>				ADDRESS (Street, city or town, state) <b>Brunswick, Md.</b> DATE SIGNED <b>2-13-58</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 14, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>LOCUST VALLEY</b>		22d. LOCATION (City, town, or county) <b>LOCUST VALLEY</b> (State) <b>MARYLAND</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elois V. Fute</b>				ADDRESS <b>BRUNSWICK, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 18 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alv. Fute</b>	

## CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
FEB 18 1958

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02006

1997

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE		
Frederick MARYLAND		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY		
Frederick	61 years	Frederick		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
242 Carroll Parkway	11 Frederick			
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH	
Alma	T.	Stull	Month Day Year	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 20-1877	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Sales clerk	Retail Shoe Store	Maryland	U.S.A.	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
Albert Locke	Mary Ellen Fogle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
No	220-05-6049	Mr. O.Clifford Stull-242 Carroll Parkway-	Frederick-Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	<i>Cerebral Hemorrhage</i> 7 day			
<i>331X</i>	DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)	DUE TO	<i>Atherosclerosis</i> & Hypertension 1 year		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I				(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>Atherosclerosis Heart Disease</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <i>July 1, 1957</i> , to <i>Sept 20, 1958</i> , that I last saw the deceased alive on <i>Sept 11, 1958</i> , and that death occurred at <i>5:00 P.M.</i> from the causes and on the date stated above.	ADDRESS (Street, city or town, state)			DATE SIGNED
ACTUAL SIGNATURE	<i>A. A. Pearre</i> M.D. 4 East Church Street			<i>2-22-58</i>
PHYSICIAN'S NAME (Type)	Frederick-Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)	(State)
Burial	Feb. 23-1958	Mt. Olivet Cemetery	Frederick	Maryland
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
<i>C. E. Cline &amp; Son</i>	Frederick-Md.	<i>FEB 24 '58</i>	<i>Alt. eaduech</i>	

## CERTIFICATE OF DEATH

MATERIAL

RECEIVED

BUREAU V. S.

FEB 24 1958

REGELIVEO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1998

## CERTIFICATE OF DEATH

Reg. Dist. No. 12007

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 Weeks					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First ROSALIE	Middle VIRGINIA	Last SUMMERS				
4. DATE OF DEATH	Month February	Day 22	Year 1958				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6 Sept 1889	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clinton Grimes		14. MOTHER'S MAIDEN NAME Mary Margaret Ramsburg					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-36-8363		17. INFORMANT Mrs. Charlotte L. Hauser, Baltimore 14, Md.		Address 6219 Harford Road,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>						INTERVAL BETWEEN ONSET AND DEATH 12 days	
<i>443 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) <i>Hypertension cardiovascular disease</i>				4 yrs +	
DUE TO		DUE TO					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec</i> , 1957, to <i>2/22</i> , 1958, that I last saw the deceased alive on <i>2/22</i> , 1958, and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>M.D. 4 E. Church St., Frederick, Md.</i>		DATE SIGNED <i>2-24-58</i>	
ACTUAL SIGNATURE <i>Henry V. Chase</i>							
PHYSICIAN'S NAME (Type) <i>Henry V. Chase, M. D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-58		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison &amp; Son, Frederick, Maryland</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <i>John J. ...</i>	

# BUREAU V. S.

- FEB. 20 1953 -

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2019

## CERTIFICATE OF DEATH

02008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>FREDERICK</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>		c. LENGTH OF STAY IN 1b <b>YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE X RURAL</b>		d. STREET ADDRESS <b>JOHNSVILLE</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RURAL, JOHNSVILLE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>CORA</b>		First	Middle	Last	4. DATE OF DEATH <b>FE B 20 1958</b>	Month	Day	Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 1-1872</b>	9. AGE (In years last birthday) <b>85 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>EMANUEL BRANDENBURG</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE JOHNSON</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>RALPH WARNER</b>		Address <b>RURAL UNION BRIDGE MD</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<b>Cerebral Hemorrhage</b>		<b>Arterio Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) <b>UNION BRIDGE</b>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>2-4-</b> , 19 <b>58</b> , to <b>2-20-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-19-</b> , 19 <b>58</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>T. H. Legg</b>		M.D.		ADDRESS (Street, city or town, state) <b>Union Bridge Md</b>		DATE SIGNED <b>2-21-58</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/23/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>METHODIST CEM.</b>		22d. LOCATION (City, town, or county) <b>JOHNSVILLE MD.</b>		
22e. FUNERAL DIRECTOR'S SIGNATURE <b>Q. H. Hartzler &amp; Sons Union Bridge Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Dee Smith</b>		24b. REGISTRAR'S SIGNATURE		
				DATE <b>FEB 25 58</b>				

## MARYLAND STATE DEPARTMENT OF HENRY - BALTIMORE, MD

## CERTIFICATE OF DEATH

NAME	AGE	SEX	DEATH DATE	TIME	CAUSE
WILLIAM JAMES LEE	50	M	APRIL 10, 1959	10:30 A.M.	HEART DISEASE
ADDRESS					
BOSTON, MASS.					
NAME OF DOCTOR					
DR. RICHARD E. COOPER					
NAME OF HOSPITAL					
GENERAL HOSPITAL					
NAME OF FUNERAL HOME					
HAROLD W. COOPER					
NAME OF ATTORNEY					
JOHN F. KENNEDY					
NAME OF POLICE OFFICER					
FBI BUREAU					
RECEIVED					
FEB 25 1959					